AUTHORIZATION FOR THE POSSESSION AND USE OF ASTHMA INHALERS OR PRESCRIBED EMERGENCY MEDICATION

This form must be provided to the principal assigned to the building of student attendance. Appropriate school staff should be notified.

Student Name: ____ Date: ________________
Address: ____

Authorization is hereby given for the student named above to:

[ ] receive the prescribed medication indicated from the designated school personnel.
[ ] self-administer the prescribed medication as permitted by law.

Medication Name: ____

Dosage: ____

Date the administration is to begin: ____________Date the administration is to cease: _____________

Adverse reactions that should be reported to the physician: _________________________________

____

Adverse reactions for unauthorized user: ____

____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: ____

____

Other special instructions: ____

____

Physician and parent/guardian names, signature, and emergency phone numbers are required.

Physician name: ____________________________________ Phone: _______________________

Signature: ____ _______________________
Date

Parent/guardian name: ______________________________ Phone: (Home) ________________
(Work) ________________
(Other) ________________

Signature: _______________________________________ _______________________
Date

Received by ___________________________________ Date _____________________________
Principal

Received by ___________________________________ Date _____________________________
Nurse

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